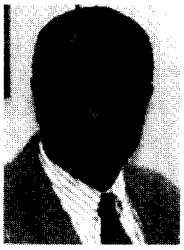
Linkage

Vol. 9, No. 2 Summer, 1999

FROM THE OFFICE OF THE DIRECTOR

INDEPENDENCE DAY



By Oscar Morgan

The summer is finally here, filled with hot, hazy days and humid nights, children are out of school, and families are planning vacations and holidays. Through it all, we find ourselves invigorated, perhaps by the longer summer days, which may renew our confidence in finding more time for family and friends. Perhaps, we're invigorated by the celebrations of our Independence. Whatever the reason, we are grateful for this renewed energy. Every July we celebrate our Independence as a Nation, standing proud and strong. It is also the second year for the Mental Hygiene Administration to celebrate its new mental health system, which was implemented July 1, 1997. Maryland's newly developed Public Mental Health System remains focused -- a system fully responsive to the people it serves -- facilitating and coordinating service systems with all stakeholders congruent with the preferences of all consumers. The Mental Hygiene Administration (MHA) is dedicated to helping persons with serious mental illness achieve the highest level of participation in community life and achieving personal independence.

Thus, this summer season marks the beginning of yet another fiscal year geared toward a stronger comprehensive mental health service system that continues to promote treatment, recovery, resiliency and health. Maryland's Public Mental Health System is a system that proudly identifies itself with enhancing fiscal efficiency and accountability, promoting ethnic and cultural diversity in its workforce and services, ensuring consumer-empowerment and freedom of choice in treatment, rehabilitation, housing, employment and all other support services.

I thank you for working with us in shaping consumers' independence, and I encourage your continued commitment. Maryland's Public Mental Health System is working, and soon will be fully reflective of what the consumer wants and needs. I am proud that our work has taken our system to this new level, and am equally proud to be able to share in that success with you.

I salute you. I hope everyone had a Happy Independence Day, and wish all a good summer! ■

The Mental Hygiene Administration, The Maryland Department of Health and Mental Hygiene

Parris N. Glendening
Governor

Georges C. Benjamin, M.D., F.A.C.P.
Secretary
Department of Health and Mental Hygiene

MARYLAND PSYCHIATRIC RESEARCH CENTER NEWS UPDATES

by Jane Clark

The Maryland Psychiatric Research Center (MPRC) recently sponsored the **7th International Congress on Schizophrenia Research** in Santa Fe, New Mexico. The event was organized by Dr. Carol Tamminga, Deputy Director of MPRC. The Congress brought together more than 1,500 world-class professionals from the basic neuroscience and clinical science communities to foster new knowledge about the disease, which is a leading challenge for medical research and affects 1% of the population. The scientific program included plenary lectures in key scientific areas of presentations of schizophrenia studies, related neuroscience research and scientific posters. In addition, the William K. Warren Schizophrenia Research Award, a congress tradition, was presented to Dr. Robert Freeman, M.D.,

Continued on back page.

THE UNITY OF HUMANITY

excerpts from Ms. Lauren N. Nile's speech during MHA's Cultural Fest March 16, 1999 as requested by attendees.

Humanity is one family. Our survival depends upon our recognition of that crucial fact. There are only four human blood types and those are universal to all of humanity. Therefore, a Swede with Type B blood can receive a transfusion from a Nigerian with Type B blood and vice versa. We can receive organs from each other irrespective of race, ethnicity and national origin. A native American, therefore, can receive a heart, liver, a lung or any other organ from a person of Japanese ancestry and vice versa.

We know we can procreate with each other irrespective of race, ethnicity and national origin. So a pygmy, for example, can either conceive or sire a fully human child with a Russian.

Our bodies require the same substances for survival and health -- the exact same oxygen, water, nutrients, and rest. We know we are contagious to each other with everything from the common cold to the most deadly of viruses.

All of these truths, we know and take for granted. But, there is a much more profound truth that the majority of us may not be aware -- a truth that we are one human family. This is not figuratively, but literally -- one human family.

Anthropologists trained in molecular biology have discovered that we all share DNA, or genes, from a single woman from whom we are all descended -- an African woman of Sub-Saharan Africa.

We know without question, the following truths:

1. Humanity began somewhere in either East or Southern Africa;
2. Some humans migrated out of Africa across land bridges to Asia, Europe, and the Americas;
3. Gradually, over time, those humans began to physically adapt to their new environments in terms of skin color, hair and facial features;
4. It takes only a few thousand years of evolution for skin color to change, and
5. In terms of our DNA, we human beings are more closely related to each other than almost any other vertebrate or mammalian species.

"It makes us realize that all human beings, despite differences in external appearance, are really members of a single entity that's had a very recent origin in one place," states Stephen Jay Gould, Harvard Paleontologist and Essayist. "There is a kind of biological brotherhood that's much more profound than we ever realized."

A Washington Post article in 1994 read, "Races don't really exist, at least not outside our imaginations. We all use race as if it meant something specific and clear-cut. . . most anthropologists say races are mostly arbitrary categories invented by people to fit a misunderstanding about how human beings evolved."

A most profound truth is that even within our common concept of race, if we define superiority as greater intelligence, there is not and cannot be any superior race. For one race to be genetically more intelligent than any other, it would have to have a larger brain than the other races. Scientists tell us that we are a very young species and that human beings have simply not evolved apart from each other long enough for such a fundamental change to have occurred in any one group.

In terms of skin color, human pigment cells make only two basic colors -- a brown-black pigment called *Eumelanin* and an orange-red pigment called *Pheomelanin*. We differ only in the amount of one as opposed to the other in our bodies. We all, therefore, have the same thing, just in differing proportions. The biological phenomenon which determines skin color, Melanin, is the very same which determines the color of eyes and hair. It would, therefore, seem preposterous to us to assert people's inferiority and to treat them as inferior beings based on the color of their eyes or the color of their hair. Yet, we do that very thing on the basis of the color of a person's skin -- is that not equally as illogical?

We are one human family. It has been estimated that every human being on the planet is at most a fiftieth cousin of any other human being. We have relied much more in our recent history on our intelligence than on our wisdom. It is time that we come together as a family and exercise our wisdom as a united whole. Our survival as a human race depends on our ability to overcome our differences and to embrace our family history. If we are to survive to avoid the mistakes of the past, and to reach our full human potential, we will need the voice and wisdom of each family member -- we need to hear and listen respectfully to the voices of native Americans, Africans, Polynesians, Aboriginal Australians, Asians, Europeans, the female majority of our species, the physically impaired, our elders. We need to accumulate the wisdom of all our spiritual traditions. We cannot spare to ignore one tradition, one voice; we need each other now more than any other time in our history.

We need to embrace our cousins and tackle the challenges facing our planet and our communities together. We need to lean upon the unity of family to give us the strength to succeed -- a unity of humanity to bring everlasting peace. ■

TRAUMA ON WOMEN AND CHILDREN

On May 19th, the Mental Hygiene Administration's (MHA) Division of Special Populations co-sponsored with the MHA's Division of Children and Adolescents a conference on **"The Effects of Trauma on Women and Children."** The conference was opened with remarks from MHA's Drs. Albert Zachik and Joan Gillece. Oscar Morgan, MHA's Director, spoke on the importance of addressing the issue of trauma in mental health treatment. He also stressed the importance of inter-agency collaborations. Dr. Joy Silberg, a consulting psychologist at Sheppard Pratt Hospital and owner of Childhood Recovery Resources, spoke on responding to childhood trauma. Dr. Silberg talked about four major trends in the field of trauma treatment for children. Dr. Andrea Karfgin, Director of Eating Disorders Institute and Clinical Supervisor of MHA's Division of Special Populations' TAMAR Project, presented on the aftermath of violence to women. A client of Dr. Karfgin allowed her own personal story to be told so that conference participants could understand the impact trauma has had on her life and the lives of thousands of women.

The conference ended with a group discussion on the gaps in trauma treatment services in participating counties. Overall the conference proved to be a success. ■

MHA thanks all Mental Health Month activity coordinators and participants. Your continued dedication, support and energy is greatly appreciated.

TBI Waiver

By Lissa Abrams

Among its many endeavors, the Mental Hygiene Administration (MHA) has undertaken the planning and development of services for individuals with traumatic brain injury (TBI). This new administrative function is separate and distinct from the Public Mental Health System and is in coordination with the other administrations in the Department of Health and Mental Hygiene (DHMH).

The Brain Injury Association of Maryland (BIAM), with the DHMH, applied to the Health Resources Services Agency (HRSA), Department of Health and Human Services for a one year planning grant. Maryland was one of the successful states awarded this grant. Currently, the grant activities are nearing completion. The purpose of the grant was to establish a statewide advisory committee, conduct a needs assessment, develop a resource directory, and complete an action plan. The project has been directed by Janis Ruoff, Ph.D. Over a six-month period a series of town meetings and focus groups were held with survivors, family members, and other interested parties throughout the State. This was an opportunity for the general public to voice their concerns regarding the gaps and barriers to receiving services. In addition, surveys were mailed to providers of service to receive feedback on needed services and resources. Surveys were mailed to State agencies to identify current services available to individuals with TBI. This information is currently being analyzed by the project staff and the action plan is being drafted. The project has been guided by the TBI Advisory Board consisting of representatives from DHMH (Mental Hygiene Administration, Developmental Disability Administration, Community Public Health Administration, Medical Assistance Administration), Maryland State Department of Education, Governor's Office of Individual Disabilities, Division of Rehabilitation Services, BIAM, and survivors, professionals, and family members.

Concurrently with the activities of the planning grant, the MHA with Medical Assistance Administration has drafted a MA waiver for individuals with TBI currently in State Psychiatric hospitals or in out-of-state MA financed rehabilitation hospitals. The purpose of the waiver is to serve individuals meeting level of care criteria for skilled nursing or chronic hospital rehabilitation in community settings. The first phase of the waiver will target this group. After the waiver is approved by the Health Care Financing Administration and implemented, the DHMH will begin work on a second phase. It is planned that the second phase will target a broader population based upon the recommendations of the TBI action plan and availability of new resources.

In the spring of 1999, MHA with the BIAM, applied for another federal grant from HRSA. This new grant is a three-year project to expand and implement strategies under the statewide action plan. The current grant application proposes to develop and implement a comprehensive training program for service providers, families, and survivors of TBI throughout the State, increase outreach activities of the BIAM, and enhance services to individuals with TBI. Notification of the states to receive these grants will be sent during the summer of 1999. For more information, call Mr. Bill Knight, MHA's Chief of Long Term Care at (410) 767-2541. ■

MHA'S DIVISION OF SPECIAL POPULATIONS

. . . did you know?

MHA's Division of Special Populations continues to coordinate, develop and oversee various programs and initiatives in addressing the mental health needs of special population groups. For example, ***did you know:***

- **The Phoenix Project** is a pre and post-booking diversion, treatment and support program for women with serious mental illness and co-occurring substance abuse disorders in Wicomico County. The project began accepting women into the program and to date (June 1999) had 22 women diverted from jail. The Phoenix Project provides a wide array of services for women and their children. The services include intensive case management, housing, integrated treatment for mental health, substance abuse, and trauma issues, linkages to other community services and agencies, and a mentoring program for their children.

- **The TAMAR (Trauma, Addictions, Mental Health and Recovery) Project** will provide treatment in three county detention centers, Dorchester, Calvert, and Frederick, as well as in the community for women with co-occurring mental illness and substance abuse disorders who are victims of violence. The project will also provide therapeutic services for their children. The Mental Hygiene Administration is in the process of hiring three trauma treatment specialists and plans to continue to conduct trauma training. Treatment services for the women should begin around September.

- The Department of Health and Mental Hygiene (DHMH) and Mental Hygiene Administration (MHA's Office of Special Populations and the Office of Forensic Services) with other State officials established the **Maryland Community Criminal Justice Treatment Program (MCCJTP),** which is a multi-agency collaborative that provides shelter and treatment services to mentally ill offenders in their communities. The program was created to serve jailed individuals with mental illness, but it now targets individuals with mental illness who are on probation and parole as well.

  The program operates in 18 counties throughout Maryland. The model features strong collaborations between State and local providers, a commitment to offering transitional case management services, the provision of long-term housing support to mentally ill offenders, and a focus on co-occurring substance abuse disorders. The MCCJTP brings both treatment and criminal justice professionals together to screen mentally ill individuals while they are confined in local jails, prepare treatment and aftercare plans for them, and provide community follow-up after their release. MCCJTP targets individuals who are 18 or older who have serious mental illness, with or without co-occurring substance abuse disorder.

  MHA's Division of Special Populations has the primary responsibility for supporting MCCJTP, providing nearly $1 million in annual funding for the program, which includes extensive research and writing of grants to provide funds from State, Federal and Local funding sources to help enhance program services. (In 1996 MHA received nearly $350,000 in Edward Byrne Memorial State and Local Law Enforcement Assistance Program funds from the U.S. Department of Justice's Bureau of Justice Assistance to hire substance abuse and mental health case managers to aid dually diagnosed offenders in seven MCCJTP jurisdictions.)

  The average MCCJTP case load is 35 clients, but the case load size ranges from 10 to 56 depending on the jurisdiction and the number of clients supervised in the community. An MCCJTP case manager helps link mentally ill offenders on intensive probation or parole with community-based services and monitors their progress following release. Each participating jurisdiction adheres to some general case management protocol: identification, screening and needs assessment, counseling and discharge planning, criminal justice system liaison, and referral and monitoring in the community. In some jurisdictions, diversion is included among the MCCJTP's objectives. (i.e. Wicomico County).

Training for both criminal justice and mental health professionals is a key objective of most local advisory boards and MHA. MHA offers regional cross-trainings for professionals involved in the criminal justice, mental health, and substance abuse treatment systems. Training assistance is provided from the GAINS Center and the Virginia Addictions Technology Transfer Center. Some counties have also developed their own training modules.

For more details on this program, call Dr. Joan Gillece at (410) 767-6603, or obtain a copy of the National Institute of Justice's Program Focus, April 1999. ■

The following abbreviated article was published in The Baltimore Times, May 14-20,1999. For a copy of the full article as originally drafted call Jean Smith at (410) 767-6629.

DEPRESSION AFFECTS AFRICAN AMERICAN COMMUNITY

The ever-increasing demands of life in the '90s may cause us to struggle "to keep it together." This struggle is real, and becomes even more complicated when combined with racism, poverty, or just finding a balance between family, job and self-worth.

These challenges put our physical and mental health at risk. "Feeling blue" is becoming more common. Many are more than just "feeling blue" -- they are clinically depressed. And, there is evidence that many African-Americans who have depression are not getting professional help.

Studies show that between the ages of 18-29, African-American women suffer from depression more than Caucasian and Hispanic women. However, African-American women aren't diagnosed until their late 30s to early 50s.

A majority of African-Americans believe that depression is a personal weakness, as compared to the general population. More than a quarter of African-Americans said they would handle depression on their own. Untreated depression can lead to loss of work productivity, alcohol and drug abuse, worsening of physical illness and suicide.

Religious faith and prayer is an important part of treatment for many individuals with clinical depression, but it is just one part of treatment. Through support of your minister, family doctor, a close friend or family member, people who suspect they have clinical depression can be encouraged to get an early, accurate diagnosis, and seek treatment.

When professional help is needed, a family doctor or trained specialist, such as a social worker, psychologist, or psychiatrist can evaluate a person for depression, recommend treatment options, and suggest support groups to help in the recovery process. Depression is treatable.

Clinical depression is not part of the aging process, although it can mimic dementia. Sadly, many elderly people are reluctant to seek the treatment that could alleviate their symptoms of depression and return them to their previous level of functioning. Our young people experience life's stress as well. There is a lot of pressure to do well in school, to win at sports, and to get along with parents, siblings, and classmates. Our children are exposed to violence, abuse, death and divorce. Children express their own signs of depression. These may include: a decline in school performance or trouble in school, feelings of sadness, regularly disobeying parents and teachers, dramatic changes in sleeping or eating habits, and difficulty paying attention or easily distracted.

For many people, clinical depression may occur as a result of or along with certain illnesses, such as diabetes, stroke, heart disease, cancer, eating, anxiety and hormonal disorders, and others. It is, therefore, important to treat the depression along with any other illness. Some medicines for treatment of physical illnesses also can contribute to clinical depression. It is essential to discuss all medications, even over-the-counter medicines, with a family physician.

Getting the facts about depression, treatment and resources available provides hope. Taking the first steps towards recovery by recognizing the need for help and getting treatment is a guarantee for better mental health.

WARNING SYMPTOMS OF CLINICAL DEPRESSION

If you experience five or more of the following symptoms for more than two weeks, see your doctor. *(Take this checklist with you.)*

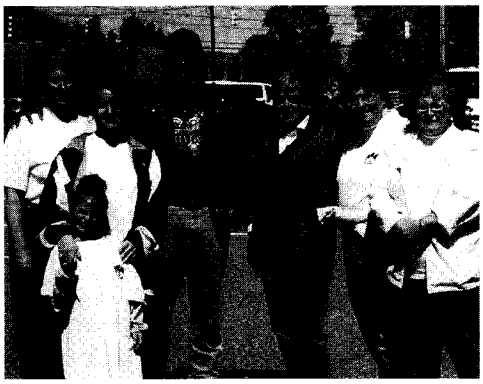
- increased appetite and weight gain (the most common sign of clinical depression in African Americans)
- reduced appetite and weight loss
- thoughts of suicide and death, or suicide attempts
- persistent physical symptoms that don't respond to treatment, like headaches, digestive disorders, dizziness and chronic pain
- irritability, restlessness, decreased energy, fatigue
- sleeping too much or too little, early morning waking
- persistent sad, anxious or "empty" feelings
- loss of interest in activities once enjoyed
- difficulty concentrating or making decisions
- feeling guilty, hopeless, worthless

MENTAL HEALTH RESOURCES

Maryland's Public Mental Health System	1-800-888-1965
Black Mental Health Alliance	410-837-2642
Baltimore Crisis Response System	410-752-2272
Depression & Related Affective Disorders Association (DRADA)	410-955-4647
Mental Health Association of MD, Inc.	410-235-1178
National Alliance for the Mentally Ill of MD, Inc.	410-467-7100
On Our Own of MD, Inc.	410-646-0262

***Mental Health Month Kick-off** at White Marsh Mall with guest speakers Delegates Alfred Redmer and Katherine Klausmeier.*

Calvert County's Mental Health Fair and Mental Health Walk.



Note from Editor: Deadline for submission of articles for the next issue of **Linkage** is **August 30, 1999**.

MARYLAND PSYCHIATRIC RESEARCH CENTER

Continued from Front Page

Professor of Psychiatry and Pharmacology from the University of Colorado Health Sciences Center. Dr. Freedman established neural system gating of information processing as a marker of genetic vulnerability, demonstrated that the nicotinic receptor was critical to gating, and then found genetic linkage near the nicotinic receptor coding site using gating as a phenotype marker in families with schizophrenia. A highlight of the conference panel discussion on "Ethical Issues in Schizophrenia Research" was organized by MPRC's Director, Dr. William Carpenter, Jr.

Paul D. Shepard, Ph.D., Associate Professor at MPRC was recently granted a 4-year award from NIMH titled, "CNS DA Neurons: Cellular Basis of Patterned Activity," which will focus on the study of the physiological mechanisms involved in regulating the electrical activity of midbrain dopamine neurons. It is anticipated that a more comprehensive understanding of these basic processes will contribute to the development of novel therapeutic approaches for the treatment of dopamine-related disorders including schizophrenia.

Adrienne C. Lahti, M.D., Associate Professor at MPRC also was recently granted a 4-year grant from NIMH titled, "Blood Flow Changes and Antipsychotic Drug Action." Dr. Lahti, using PET imaging technology, will study how antipsychotic medications affect brain metabolism and how these changes predict drug response.

Additional information can be found at MPRC's Website: *www.umaryland.edu/mprc.* ■

Linkage

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